EXPEDITED TBS PROCESSING REQUEST

COUNTY of SAN DIEGO
Therapeutic Behavioral Services
TBS

(Expedited Request accepted only by Medi-Cal Beneficiary's primary ongoing treating MH provider)

Mental Health Services Provider Information	**Medi-Cal Beneficiary Information**
Treating Provider Name:	Medi-Cal Beneficiary Name:
Treating Provider / Agency Contact Information: Address: _____ _____ Phone #: _____ Provider #: _____	Beneficiary Medi-Cal Number: MC #: _____ DOB: _____

Please check the reason for this Request for Expedited Processing: *(check which below apply)*

_____ Without TBS, the beneficiary is likely to be placed at a higher level of care or to require acute psychiatric hospitalization within the next 14-21 days.

_____ The beneficiary is ready to transition to a lower level of care within the next 14-21 days but cannot do so without TBS.

Provider Certification:

I certify under penalty of perjury that this Expedited Processing Request is necessary because the standard timeframe to begin TBS could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function.

Signature of MH Provider: _____ Date: _____